DCH/LMC-040 (05/04)

Michigan Department of Community Health
Board of Marriage and Family Therapy
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

MARRIAGE AND FAMILY THERAPY LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Marriage and Family Therapy. Questions regarding your application can be directed to the Michigan Board of Marriage and Family Therapy at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time.

LIMITED LICENSE

1. Complete the marriage and family therapist application and submit it with the appropriate fee to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Arrange for an official transcript of your master's or higher-level degree to be sent to this office directly from your educational institution. The transcript must show the degree earned and the date conferred as well as all course work required for licensure.

3. Submit course descriptions or syllabi for the course work you list on your application. Graduates of master's programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to submit the course descriptions or syllabi.

4. Complete Section I of the Supervisor's Evaluation of Applicant's 300 Hours of Direct Client Contact form, forward it to your supervisor for completion of Section II, and have your supervisor submit it directly to the Board office.

FULL LICENSE BY EXAMINATION

1. Complete the marriage and family therapist application and submit it, along with the appropriate fee, to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. If you have held a Michigan Marriage and Family Therapist Limited License and are now applying for full licensure, you must complete Section I of the Supervisor's Evaluation of Applicant's 1,000 Hours of Direct Client Contact form, forward it to your supervisor for completion of Section II, and have your supervisor submit it directly to the Board office.

3. If you are applying for a full license and have not held a Michigan limited license, you must:

    a) Arrange for an official transcript of your master's or higher-level degree to be sent to this office, directly from your educational institution. The transcript must show the degree earned and the date conferred as well as all course work required for licensure.

    b) Submit course descriptions or syllabi for the course work you list on your application. Graduates of master's programs or doctoral programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to submit the course descriptions or syllabi.

    c) Complete Section I of the Supervisor's Evaluation of Applicant's 300 Hours of Direct Client Contact form, forward it to your supervisor for completion of Section II, and have your supervisor submit it directly to the Board office. Graduates of doctoral programs accredited by

the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to verify your practicum or work experience hours.

b) Complete Section I of the Supervisor's Evaluation of Applicant's 1,000 Hours of Direct Client Contact form, forward it to your supervisor for completion of Section II, and have your supervisor submit it directly to the Board office. Graduates of master's programs or doctoral programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) do not have to verify your practicum or work experience hours.

4. Verification of licensure from any state where you hold or have ever held a permanent marriage and family therapist license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

5. After all of the above licensure requirements are completed, the Board will forward you an application for the AMFTRB Examination in Marital & Family Therapy. Instructions on how to register for the examination will be included.

FULL LICENSE BY ENDORSEMENT:

1. If you are currently licensed in another state and have been licensed for a minimum of five years, complete the marriage and family therapist application and submit it, along with the appropriate fee, to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Verification of licensure from any state where you hold or have ever held a permanent marriage and family therapist license. A form is enclosed for this purpose and may be copied as needed. As most states charge a fee for this service, you should contact each state board to determine if a fee is required prior to sending them the form for completion. The Verification of Licensure form must be sent to the Michigan Board directly from the state(s) where you are or have been licensed.

3. All other applicants for licensure by endorsement, not meeting the above requirements, must meet the education, practicum, experience, and examination requirements listed for applicants for the license by examination.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Marriage and Family Therapy in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Marriage and Family Therapy in writing to request a refund.

3. ***If you will require special testing accommodations because of a disability, you must submit a letter indicating the accommodation requested and your disability. You must also submit documentation and/or test results verifying the disability and the requested accommodation from a licensed health provider capable of making the diagnosis. We also need a letter from school personnel verifying the accommodations made during your education. These documents should be sent as soon as possible to the following address: Department of Community Health, ATTN: ADA Request, P.O. Box 30670, Lansing, MI 48909.***

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A TWO-YEAR PERIOD.

Michigan Department of Community Health
Board of Marriage and Family Therapy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

APPLICATION FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Board Use Only
License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ☐ **Full License by Examination - Fee: $85.00 71-4101-01**
- ☐ **Full License by Endorsement - Fee: $85.00 71-4101-09**
- ☐ **Limited License - Fee: $85.00 71-4101-05**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Have you ever held a health professional license in Michigan?

☐ No ☐ Yes

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	☐ Yes	☐ No

Name

9. Do you hold or have you ever held a Marriage and Family Therapy license in any state? List each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPOARY LICENSES. **You must have each state board verify licensure directly to the board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your MFT education. Attach additional sheets if necessary.

Is this program is COAMFTE accredited? ☐ Yes ☐ No

Name and Address of Institution	Dates of Attendance From	To	Degree

List course work that includes study in the following required areas. Credit for any course can be counted only once. All courses must be graduate level courses. You must submit course syllabi for all courses listed.

Name and Address of College	Course #	Course Title	List # of Hous (indicate semester or quarter hours)
FAMILY STUDIES - 3 courses required. Must total 6 semester or 9 quarter hours.			
FAMILY THERAPY METHODOLOGY - 3 courses required. Must total 6 semester or 9 quarter hours.			
HUMAN DEVELOPMENT- PERSONALITY THEORY, OR PSYCHOPATHOLOGY - 3 courses required must total 6 semester or 9 quarter hours.			
ETHICS, LAW AND STANDARDS OF PROFESSIONAL PRACTICE. Must total 2 semester or 3 quarter hours.			
RESEARCH. Must total 2 semester or 3 quarter hours.			

Name

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Marriage and Family Therapy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

SUPERVISOR'S EVALUATION OF APPLICANT'S 1000 HOURS OF DIRECT CLIENT CONTACT

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

EXPERIENCE REQUIREMENTS

Following the completion of the education required for licensure, you must have obtained a minimum of **1,000** direct client contact hours in supervised marriage and family therapy experience. At least 500 of these hours must be completed with families, couples, or other subsystems of families physically present in the therapy room. A licensed marriage and family therapist must provide the supervision.

200 hours must be completed with a supervisor present, 100 hours of this supervision must be individual supervision with no more than one supervisee present. The remaining hours may be group supervision with more than six supervisees present.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to your supervisor for completion of Section II. This certification must be submitted directly to the Michigan Board of Marriage and Family Therapists by your Supervisor.

Applicant's Name (First, Middle, Last)	
Street Address	
City	
State	ZIP Code
U.S. Social Security Number	Date of Birth

Signature of Applicant	Date

Applicant: Upon completion of Section I, send this form to your supervisor for completion of Section II.

Name

SECTION II - SUPERVISOR'S EVALUATION

Please complete the following information. Return this completed form directly to the Michigan Board of Marriage and Family Therapy at the address shown on the front of this form.

Name of Supervisor

Name of Agency or Clinic

Address

City, State and ZIP Code

Were you a licensed Marriage and Family Therapist during the time you supervised the applicant?

☐ YES ☐ NO

License Number _____

Issued by which State? _____

Applicant worked under my supervision from: _____ (Month) _____ (Year) to: _____ (Month) _____ (Year)

Under my supervision, the applicant has completed a total of _____ hours of direct client contact in supervised marriage and family therapy experience.

OF THE TOTAL DIRECT CLIENT CONTACT HOURS STATED ABOVE:

a. _____ hours of direct client contact were completed with families, couples, or other subsystems of families physically present in the therapy room.

I have provided the applicant a total of _____ face to face hours of supervision during the dates indicated above.

OF THE TOTAL HOURS OF FACE TO FACE SUPERVISION STATED ABOVE:

a. The applicant has received _____ hours of supervision in which only one or two supervisees were present.

b. The applicant has received _____ hours of supervision in which only three to six supervisees were present.

_____ Supervisor's Signature

_____ Date

Michigan Department of Community Health
Board of Marriage and Family Therapy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

SUPERVISOR'S EVALUATION OF APPLICANT'S 300 HOURS OF DIRECT CLIENT CONTACT

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

EXPERIENCE REQUIREMENTS

You must provide proof verified by your supervisor of having completed 300 hours of direct client contact, at least half of which were completed in a setting where families, couples, or subsystems of families were physically present in the therapy room, and having completed 60 hours of supervised clinical experience over at least eight consecutive months in either A CLINICAL PRACTICUM DURING GRADUATE EDUCATION **OR** IN A POSTGRADUATE MARRIAGE AND FAMILY THERAPY INSTITUTE ACCEPTABLE TO THE BOARD.

A practicum supervisor must be one of the following: a licensed marriage and family therapist; a certified social worker or social worker registered; a licensed professional counselor; a physician practicing in a mental health setting; a fully licensed psychologist; or an approved supervisor or supervisor-in-training through the AAMFT.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to your supervisor for completion of Section II. This certification must be submitted directly to the Michigan Board of Marriage and Family Therapists by your supervisor.

I AM APPLYING FOR THE FOLLOWING:

NOTE: This form is required if you are applying for a limited license OR for full licensure and you have not held a limited license.

☐ Full License

☐ Limited License

First Name	Middle Name	Last Name

Street Address

City

State	ZIP Code

U.S. Social Security Number	Date of Birth

Signature of Applicant	Date

Applicant: Upon completion of Section I, send this form to your supervisor for completion of Section II.

Name

SECTION II - SUPERVISOR'S EVALUATION

Please complete the following information. Return this completed form directly to the Michigan Board of Marriage and Family Therapy at the address shown on the reverse side of this form.

Name of Supervisor

Name of Agency or Clinic

Address

City, State and ZIP Code

Which of the following were you at the time of supervision (Check One):

- ☐ a licensed marriage and family therapist
- ☐ a certified social worker or social worker registered
- ☐ a licensed professional counselor
- ☐ a physician practicing in a mental health setting
- ☐ a fully licensed psychologist
- ☐ an approved supervisor or supervisor-in-training through the AAMFT

Please provide your license number for the professions you checked.

License # _____

Issued by Which State? _____

Applicant worked under my supervision from: _____ Month _____ Year to: _____ Month _____ Year

Applicant's experience was obtained in a ☐ Clinical practicum during graduate education **OR** in a ☐ postgraduate marriage and family therapy institute.

Please name organization or institute where experience was obtained:

_____

The applicant has completed _____ hours of direct client contact.

Of the total direct client contact hours, the applicant has completed _____ hours in a setting where families, couples, or subsystems of families were physically present in the therapy room.

The applicant has completed _____ hours of supervision of clinical experience over _____ consecutive months.

_____ Supervisor's Signature

_____ Date

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.